American Medical Group Association
Testimony

The debate regarding Provider Sponsored Organizations (PSOs) will be contentious, because the issues involved are crucial to competition for patients by all of the special interests involved in the debate. Please bear in mind that quality of care for patients, the accountability of systems for the care provided, and the impartiality of relationships between medical care systems and the business of insurance are critical to a fair market. The American Medical Group Association would like to commend the Committee for taking up this issue so early in the session.

- We believe the proposal holds promise for higher quality, coordinated care for Medicare beneficiaries.
- We believe that an expanded range of health plan options in Medicare markets will lead to scorable savings in the Medicare program.
- We believe that a Provider Sponsored Organization option will be a valuable and popular addition to the current range of options available to Medicare and Medicaid beneficiaries.
- We believe the task of improving the quality of care which patients receive requires a systematic and concerted effort that is resource, time and capital intense.
- We believe that physician leadership is critical in any high-quality health care delivery system. If non-medical managers who answer to a board of directors, or business executives who answer to shareholders, are in a position to set health care policies or make health care decisions, quality will give way to cost.
- We believe federal legislation and regulation must assure that quality of care and accountability for health care services resides with physicians and not with health plans, insurance companies or HMOs.
- We believe patient care, despite all the talk about health plans and traditional insurers, is the responsibility of physicians and other individuals providing care under their supervision. Physicians are professionally accountable for the care their patients receive. Medical decisions are made by physicians in consultation with the patient and other health care providers as appropriate. Because of this, the doctor-patient relationship is critical, and the integrity of this relationship must be preserved.
- We are concerned about the long-term effect insolvencies might have on the medical marketplace. Consequently we are pleased that the authors of the bill have been appropriately conservative in the requirements set forth to protect consumers.
- We believe payments to Medicare managed care plans should be risk adjusted to take into account the higher costs of treating people with chronic and more expensive health problems.

We appreciate the leadership of Representative Greenwood of this Committee and Representative Stenholm, as well as Senators Frist and Rockefeller in initiating this debate. We look forward to the opportunity to support the Committee's efforts to improve care for Medicare beneficiaries.

Introduction

Mr. Chairman and Members of the Committee, I am Dr. Robert Margolis, chairman of the American Medical Group Association, and Managing Partner of Health Care Partners a 330 physician multi-specialty group practice which provides care to more than 250,000 commercial patients, 40,000 Medicare beneficiaries in both capitated and fee-for service reimbursement modalities at 30 sites throughout the Los Angeles area. I am board-certified in internal medicine and medical oncology with a medical degree from Duke University. I appreciate the opportunity to testify before the committee today.

Both predecessor organizations which merged to create the American Medical Group Association supported Provider Sponsored Organization (PSO) legislative proposals during the last session of Congress. Formed by the 1996 merger of the American Group Practice Association and the Unified Medical Group Association, AMGA now represents over 200 of the nation's most innovative and prestigious medical groups and more than 40,000 physicians practicing in those groups.

Our membership includes many of the most highly-respected multi-specialty medical groups in the country, including the Watson Clinic, the Mayo Clinic, the Marshfield Clinic, the Dean Health Center, the Portland Clinic, the Oklahoma City Clinic, the Lewis Gale Clinic, the Lexington Clinic, the Scott and White Clinic, the Cleveland Clinic, The Henry Ford Health System, Scripps Clinic Medical Group, Permanente Medical Groups,

MedPartners-Mullikin, HealthCare Partners and many others. *All of AMGA's members are governed and managed by physicians: a factor that we believe is essential to the successful delivery of high-quality, cost-effective health care.*

AMGA is dedicated to the advancement of these integrated health care delivery systems, and we are eager to work with the Committee and the nation's leaders to find equitable solutions to increase Americans' access to the highest quality, affordable health care.

I want to commend the Committee for taking up this issue so early in the session. The debate regarding Provider Sponsored Organizations (PSOs) will be contentious, because the issues involved are crucial to competition for patients by all of the special interests involved in the debate. Please bear in mind that quality of care for patients, the accountability of systems for the care provided, and the impartiality of relationships between medical care systems and our insurance partners are critical to a fair market.

I am here today to offer support for this proposal. We believe the proposal holds promise for higher quality, coordinated care for Medicare beneficiaries. We believe that an expanded range of health care delivery options in Medicare markets will lead to measurable savings in the Medicare program. We believe that a Provider Sponsored Organization option will be a valuable and popular addition to the current range of options available to Medicare and Medicaid beneficiaries. In fact some of our members believe that such a Medicare option will be so attractive to high-risk patients that our members are reluctant to enter this market until Medicare has developed a fair mechanism for risk

adjustment. Others, on the other hand, will not compete in (primarily rural) risk markets until HCFA can assure an adequate and stable reimbursement rate.

We believe that physician leadership is critical in any high-quality health care delivery system. If non-medical managers who answer to a board of directors, or business executives who answer to shareholders, are in a position to set health care policies or make health care decisions, quality will give way to cost.

A Provider Sponsored Organization option will not be a panacea, but it will be an added dimension, that will increase competition in the medical marketplace, and it will help focus patients' attention on delivery of care processes. It may well be an antidote to some of the poison of financial intervention in clinical decision-making.

Patient care, despite all the talk about health plans and traditional insurers, is the responsibility of physicians and other individuals providing care under their supervision. Physicians are professionally accountable for the care their patients receive. HMOs do not deliver health care; doctors do. Insurance companies do not practice medicine; physicians do. Medical decisions are made by physicians in consultation with the patient and other health care providers as appropriate. Because of this, the doctor-patient relationship is critical, and the integrity of this relationship must be preserved.

Federal legislation and regulation must assure that quality of care and accountability for health care services resides with physicians and not with health plans, insurance companies or HMOs.

We are concerned about the long-term effect insolvencies might have on the medical marketplace. Consequently we are pleased that the authors of the bill have been appropriately conservative in the requirements set forth to protect consumers.

Mr. Greenwood, we appreciate the leadership you and Representative Stenholm, as well as Senators Frist and Rockefeller have provided in initiating this debate. We look forward to the opportunity to support your efforts to improve care for Medicare beneficiaries.

THE MEDICARE PROVIDER-SPONSORED ORGANIZATION ACT OF 1997

AMGA supports legislation which would allow "provider-sponsored organizations" (PSOs) to contract directly with HCFA to deliver medical services to Medicare beneficiaries.

Under current law, Medicare beneficiaries can choose to receive their care under a traditional fee for service arrangement or from an HMO. The bill would create a third option aimed at keeping health care decisions in the hands of the provider and the patient.

Under this bill, there would be a four year window from 1998 to 2002, when PSOs would be certified to provide benefits to Medicare beneficiaries at the federal level. Medicare contracts with PSOs would not require, and states would be preempted from requiring, state HMO or insurance carrier licenses for at least the first four years.

The authors of the bill believe that state insurance licenses should not be necessary for Medicare to enter into service contracts with health providers. The lengthy process for obtaining HMO licenses would slow Medicare movement into coordinated care.

A "qualified" PSO would be paid on a capitated prospective basis. To be considered as qualified, a PSO must provide a substantial proportion (as defined by HHS) of the health care items and services under the contract directly through the provider or through an affiliated group of providers that comprise the organization. Affiliated providers are those that share a significant common economic interest through common control or ownership, or who share substantial risk. The bill suggests that a "substantial proportion" means significantly more than a majority of contracted services, with most of the remaining services covered by written agreements that protect consumers.

Standards

PSOs would fall under the same standards and contracting arrangements that now apply to Medicare risk contractors, HMOs, and CMPs, but with a limited number of changes

crafted to eliminate barriers to PSOs while maintaining consumer protection and emphasizing quality assurance.

The bill would waive the 50/50 rule for any risk contractor that met new, enhanced quality requirements. The 50/50 rule currently states that a health plan's Medicare and Medicaid enrollees cannot exceed 50 percent of its total enrollment. The rationale behind the rule is that if a plan has more than half of its enrollees from the private sector, it will maintain a high quality of care, compared with an enrollment base mainly comprised of Medicare or Medicaid beneficiaries. Waiver of this requirement is especially necessary for risk contractors in rural areas to serve the disproportionate share of elderly in these areas. Therefore, the minimum enrollment levels would be changed for all contractors from 5,000 to 1,500 and from 1,500 to 500 for risk contractors serving rural areas.

Under the proposal, the current Medicare requirement that a plan's enrolled population include at least 50 percent commercial enrollees (the 50/50 rule) would be waived for any risk contractor that met the following requirements. The PSO must have an ongoing quality assurance program that A) stresses health outcomes; B) provides opportunities for input by physicians and other health professionals; C) monitors and evaluates high volume and high risk services and the care of acute and chronic conditions; D) evaluates the continuity and coordination of care that enrollees receive; E) establishes mechanisms to detect both the underutilization and overutilization of services; F) after identifying areas for improvement, establishes or alters practice parameters; G) takes action to improve quality and assess the effectiveness of such action through systematic followup; H) makes

available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options; and I) is evaluated on an ongoing basis as to effectiveness.

If the PSO utilizes case-by-case utilization review in its quality assurance program the PSO must base its UR on written protocols developed on the basis of current standards of medical practice. The PSO must also implement a plan to coordinate UR with the quality assurance program, phasing out case-by-case review, and transition to methodologies which focus on patterns of care.

The bill also establishes fiscal soundness and solvency standards that must be met for a PSO to be federally qualified. The bill specifies explicit as well as general measures for fiscal soundness which reflect current HMO and insurance regulatory practices, modified to recognize the different operational characteristics of qualified PSOs.

The authors of the legislation believe that PSOs are not insurance companies. Their primary business is the delivery of care, not the pooling and spreading of risk. The core business of integrated delivery systems which could qualify as a PSO is health care delivery, rather than insurance, and the assets of such organizations are used predominantly to deliver care to patients under a variety of payment methods including but not necessarily limited to capitated risk payments from Medicare.

Under the bill the fiscal soundness of such organizations may be demonstrated either by meeting specific net worth and reserve requirements or through reliance on a combination of factors which ensure an adequate cushion against unexpected events. For the purpose of demonstrating the net worth of a PSO, the value of land, buildings, and equipment, and receivables from governmental programs due for more than 90 days would be admitted as assets of the organization.

For the purpose of demonstrating the solvency of a PSO, a variety of alternative measures in common practice within the insurance industry may be employed. Letters of credit, financial guarantees, reinsurance and stop loss insurance, actuarial certifications, unrestricted fund balances, the presence of non-risk related revenue and diversity of lines of business will all be taken into consideration by the Secretary of HHS in licensing a PSO to accept Medicare risk.

The Advantage of Medical Group Organizations

The Committee is well aware of the revolutionary changes sweeping health care financing and delivery in the United States. AMGA urges the committee to carefully examine the financing, organizational structure and delivery of health services by integrated, medical group practices. We believe that these systems are playing and will continue to play a distinct and vital role in the American health care system.

Clearly, the increased emphasis on the costs and quality of medical care has created the need for better management and more organization in the delivery of health care services. For many years, integrated, medical group practices have recognized that in delivering health care, cost and quality are inseparable. As a result, these systems have evolved and will continue to evolve into highly-sophisticated systems in which patient care is managed for the best outcomes by emphasizing the value of teamwork—an interdisciplinary approach to patient care that focuses on improving the functional status, quality of life and the health of patients.

In fact, the success of integrated group practices can be attributed in large part to their shared mission and their unique culture. They share a commitment to coordinated health care by providers concerned about prevention, education and management of chronic conditions, as well as the treatment of acute conditions. This commitment has been at the heart of the group practice movement for several decades. As a result, group practice patients benefit from quality care management fostered by an organized system of delivering care that encourages peer review, cross training, professional development, and constant measurement of results.

Many group practices and integrated delivery systems form the core of a managed care organization's delivery system, accepting full or partial capitation for the care of patients, while others own and operate health plans and are fully state licensed. These organizations are prepared to enter the PSO market and compete head to head with other Medicare risk contractors.

Whether they will or not is yet to be seen. In some markets, it would be suicidal for a fully integrated system to compete with its best partner in business, the managed care organization or the predominant insurer in the community. In other markets, the sledgehammer management styles of insurers has turned existing integrated systems into sweatshops, and the physician and provider community is seriously considering unionizing to offset short-term bottom line management decisions which are compromising both physicians and patients. In these and other markets the mere availability of the PSO options will alter the balance between contract negotiations, resulting in more favorable terms for the physicians and providers who deliver care. We believe this shift in the negotiating strength will result in lower costs, better access to high quality care and enhanced focus on issues related to clinical quality improvement.

A Commitment to Quality

Provider-sponsored organizations should be held to high standards that ensure consumer protection and quality assurance. But much can be said about quality without ever addressing it. The President is still considering the appointment of a managed care/quality commission. Congress recently enacted maternity length of stay legislation, which for the first time ever, tells doctors how to treat their patients. And there are indications that this is only the tip of the legislative iceberg, with signs that we shall see, in the 105th Congress, gag-clause legislation, mastectomy length of stay bills, anti-managed care legislation, and an avalanche of proposals drafted to protect disenfranchised providers, and obsolete

technologies. It is a slippery slope and one we hope that the Congress will be reluctant to scale. AMGA understands the good intentions which motivate these and other bills, but they interfere with medical judgment, and the appropriate allocation of resources to assure the highest quality of care for the greatest number of beneficiaries. Mandates sidetrack resources that can more effectively be applied to treatment and prevention of avoidable disease.

AMGA would like to remind the Committee of that which you already know: That true quality in patient care cannot be mandated by any regulatory body. It can only be realized when health systems are structured in such a way that incentives support doing what is best for the patient.

The recent flurry of legislation and regulation related to the perceived abuses of managed care does little if anything to ameliorate health care quality problems. At best, they may have an indirect effect, caused by the overall perception that health care is being scrutinized more carefully. At worst they are entirely irrelevant and obstructive to quality improvement. The task of improving the quality of care which patients receive requires a systematic and concerted effort that is resource, time and capital intense.

AMGA's members have long been at the forefront in the pursuit of clinical quality improvement. For many years, they have realized that quality management and outcomes research must serve as the cornerstones of quality medical care. For our members, outcomes measurement and research provides a scientific basis for patient care

management. In fact, the group practice setting is ideal for large-scale outcomes measurement and the application of continuous quality improvement because care tends to be delivered in a comprehensive manner to large and stable populations.

Many AMGA members use their outcomes findings to define the best care management practices and protocols, which can be further developed and tested within the groups. In fact, as organized systems of care, our groups have developed complex and technologically advanced information systems that enable them to constantly evaluate practice patterns to make continuous improvements. This work leads to better treatments and outcomes for patients, and as a result, cost savings.

AMGA physicians have found that quality outcomes measurements go a long way towards assuaging the fears of our patients. There are populations within our health care system that are vulnerable and need to be followed more carefully. For a number of years, AMGA's medical groups have been tracking potentially vulnerable groups of patients to assure that sufficient attention is paid to undiagnosed health conditions and prevention.

For example, we have learned that 33% of patients with diabetes screen positive for risk of depression. The data also show that those who screen positive for depression have significantly lower average scores on all diabetic functioning scores than patients screening negative for depression. Armed with this information, clinicians treating patients with diabetes can direct services toward diagnosing and treating all underlying symptoms in addition to the diabetes itself.

None of this is rocket science, but there is a great deal of medical learning that is yet to take place. Outcomes research is in its infancy and can only be put in place by organizations that can aggregate data from a wide variety of sources within the organization. Integrated delivery systems and provider sponsored organizations are some of the few entities that have the existing resources and the clinical management to engage in this essential research.

Consumer Protection and Solvency

One of AMGA's primary concerns in its consideration of the Greenwood/Stenholm PSO bill relates to the problematic area of assuring that new organizations licensed to provide Medicare services do not compromise the future of market reforms by failing to adequately protect Medicare beneficiaries. We are pleased to see that the standards are even more detailed and explicit than current Medicare law relating to quality and solvency for HMOs. Beneficiaries will be protected from incurring any financial liability if a PSO became insolvent.

AMGA supports the concepts recently announced by the Physician Payment Review Commission that would apply the same core standards to all private health plans participating in the Medicare program, with flexibility to develop and enforce such standards. In recognizing the legitimate differences between provider-sponsored

organizations (PSOs) and insurance companies, we strongly believe that PSOs should be held to equivalent, but not necessarily identical, solvency standards as insurers.

PSOs that are financially and clinically integrated represent the best models capable of providing care for a comprehensive Medicare benefit package while assuming financial risk for those services. The entry of qualified PSOs into Medicare markets will complement the existing menu of health care services, and challenge all other organizations to lower costs, improve care, and preserve relationships between patients and those individuals who provide their care.

Competition

Medicare is one of the fastest growing segments of the managed care markets. Competition for Medicare enrollees has increased further with the expansion of the Medicare Select program, and the addition of other new Medicare options.

The market is expected to grow even more competitive in the near future if Congress permits providers to go directly at risk for Medicare patients as participants in provider-sponsored organizations.

AMGA's experience has been that as seniors become more aware of the coverage afforded through most HMOs, the attractiveness of an HMO option increases. Patients are attracted to the Medicare managed care concept because of the idea that they have

"one stop shopping." That is, one medical group provides all of their health care services – often in one location. This is a core strength of certifiable PSOs and integrated systems of care. AMGA member organizations are made up of physicians -- of many specialties – who practice together, believing that this is the best way to provide care. Our group practice philosophy naturally complements the desire of patients to have health care provided – as much as possible -- in one location.

AMGA would like to emphasize that our members define managed care first and foremost as the management of actual patient care or **care management** in order to provide the most appropriate, high-quality cost-effective care. To AMGA medical groups, managed care can not be defined as simply the management of dollars.

In fact, AMGA represents systems that have adopted a variety of different payment mechanisms, including both fee-for-service and capitation. And in fact, the group practice mode of delivering health care existed long before the cost containment pressures of the past two decades. A commitment to coordinated health care has been at the heart of the group practice movement for several decades. Even in a fee-for-service context dominated by indemnity style insurance, group practices have embraced delivery systems of coordinated providers that manage patient care using a multispecialty model.

Within AMGA, this shared view of the best way to care for patients is the common ground where group practices that have operated largely in a fee-for-service context have come together with prepaid group practices. Managed care techniques, including

utilization review, quality improvement programs, case management, capitated reimbursement of physician groups, reliance on primary care and exclusive networks of carefully selected, integrated providers, have been integral to many medical group practices long before managed care spread because of cost pressures.

AMGA medical groups see on an almost daily basis that seniors usually live on fixed incomes. For this reason, "cost" is another factor that AMGA would ask the Committee to keep in mind. Medicare managed care can be provided to beneficiaries in such a way that saves beneficiaries' financial resources. According to HCFA, nearly two-thirds of all Medicare managed care plans currently offer a zero premium product. This is a 40 percent increase in the last five years.

But it is interesting that zero-premium plans have sometimes raised concerns among seniors. Many of our medical groups have found that our physicians must spend considerable time educating beneficiaries who do not understand how a plan can deliver good health care without charging some kind of premium. This is especially true in areas with little or no experience in managed care. We know these concerns are unfounded. As more and more Medicare beneficiaries recognize the comprehensive quality and value of health care services provided through integrated delivery systems we expect to attract large volumes of patients.

Risk Adjustment

Payments to Medicare managed care plans should be risk adjusted to take into account the higher costs of treating people with chronic and more expensive health problems. Plans with a demonstrably higher share of beneficiaries with expensive chronic diseases should be paid more. The Medicare program needs to move quickly to improve its ability to adjust payment rates to reflect differences in the health status of Medicare beneficiaries. Without better risk adjustment, medical groups with excellent programs for patients with chronic diseases may be reluctant to offer their own Medicare health plans for fear of adverse risk selection.

Conclusion

In closing, AMGA believes that Medicare patients have unique needs and characteristics. AMGA medical groups have designed Medicare managed care plans with these needs in mind. The needs of the Medicare population require a coordinated care approach – which multi-specialty group practices are perfectly situated to deliver. The organizations we represent look forward to the opportunity to make the finest medical services widely available and affordable.